Appendix A: Best Practice Resources

Adult Mental Health Resources

The following would be helpful for additional Best Practice resources.

Evidence Based Practice

http://mentalhealthpractices.org

For general reference see:

http://tecathsri.org/nimh-samhsa/nimh-samhsa-presentation.pdf

APA Practice Guidelines:

http://www.psych.org/clin_res/prac_guide.cfm

Center for Evidence Based Mental Health:

http://cebmh.warne.ox.ac.uk/cebmh/index.html

NY Office of Mental Health:

http://www.omh.state.ny.us/omhweb/aboutomh/Videos.html

National Guideline Clearinghouse:

http://www.guidelines.gov/index.asp

HSRI Evaluation Center:

http://www.tecathsri.org/knowledge.asp

University of Maryland:

http://www.hshsl.umaryland.edu/resources/evidence.html#SOCIALWORKME

Crisis Services:

www.emergencypsychiatry.org

Jail Diversion:

www.bazelon.org/decrim.html

The Cochrane Collaborative:

http://www.update-software.com/cochrane/abstract.htm

Behavioral Healthcare Resource Program:

http://ssw.unc.edu/bhrp

State of Tennessee Dept. of MH:

www.dualdiagnosis.org

Illness Self-Management:

www.bhrm.org/guidelines/illness-self-mgmt.pdf.

NAMI ACT Manual:

www.nami.org/about/pact.htm

Recovery Resources:

http://www.mentalhealth.org/consumersurvivor/recovery.asp

There are other resources that may not be available on-line, but nevertheless might serve as good resources. These include the following:

"The Dual Disorders Integrated Treatment Fidelity Scale" developed by Bob Drake, et al., at the New Hampshire – Dartmouth Psychiatric Research Center.

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations developed by the Agency for Health Care Policy and Research, and the NIMH.

The Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment developed by the International Association of Psychosocial Rehabilitation Services (IAPRS).

Child Mental Health Resources

1. For more information on Wraparound see:

Bridges 4 Kids: http://www.bridges4kids.org/Wraparound.html

Burchard, J.D., Bruns, E.J., & Burchard, S.N. (2002) The Wraparound Approach. In B. Burns & K. Hoagwood (Eds.) Community-Based Interventions for Children and Families. Oxford: Oxford University Press. http://www.uvm.edu/~wrapvt/approach.htm

2. Community Treatment for Youth; Evidence-Based Interventions for Severe Emotional and Behavioral Disorders, Barbara J. Burns and Kimberly Hoagwood, Oxford University Press, 2002

3. When The Bough Breaks The Cradle Will Fall: Promoting The Well Being Of Infants And Toddlers In Juvenile Court", Lederman, Osofsky and Katz, Juvenile and Family Court Journal, 2001

4. Assessment, Clinical Case Management with other Substance Abuse Services. (Bois, C. and Graham, K. Assessment, case management, and treatment planning. In: Howard, B.M.; Harrision, S.; Carvier, V.; and Lightfoot, L., eds. Alcohol and Drug Problems: A Practical Guide for Counselors. Toronto, Ontario: Addiction Research Foundation, 1993. pp. 87-102)

5. Transition to Independence Process (TIP) System web site:
http://www.fmhi.usf.edu/cfs/policy/tip/systemdesc.htm

6. Description of home-based model: www.familytraumaservices.com/home_based_services.htm

7. Home-based model with MST:

www.psychiatrictimes.com/p000321.html

8. Info on systems of care for children:
http://www.mentalhealth.org/cmhs/ChildrensCampaign/1998execsum5.asp

9. Best Practices in Respite Care – Canada: www.cfc-efc.ca/docs/cacc/00001_en.htm

10. Parent to Parent Study: http://www.parenttoparent.org/Y-STDY.HTM

11. Family to Family Foster Care: www.4children.org/news/300ftf.htm

12. Multiple Response System: http://www.dhhs.state.nc.us/dss/childrensservices/mrs/index.htm

13. Preventing mental disorders in school age children:
http://journals.apa.org/prevention/volume4/toc-mar30-01.htm

Developmental Disabilities Resources

Since we have defined Best Practice as being "responsive and effective in the experience of the individual", we must find new methods to evaluate the effectiveness of the "strategies" we use to support individuals with developmental disabilities. Traditional "quality assurance" methods have often focused on the process rather than the outcome. These methods often improve the quality of "programs", but do little to improve the personal outcomes for individuals.

In order to shift the focus, evaluation procedures must concentrate on the outcomes that individuals desire and need. Additionally, we must evaluate our system based on outcomes that reflect the values established within the state plan.

Two examples of tools that may be used for such evaluation are the Council on Quality Leadership in Supports for People with Disabilities, Personal Outcomes Tool and the National Association of Developmental Disabilities Program Directors, Core Indicators Project, both of which evaluate how supports and services achieve consumer outcomes. The Personal Outcomes Tool focuses on individuals while the National Core Indicators Project may be more useful for system evaluations.

Regardless of the tools used, it is most important that we shift our focus from process goals to an evaluation system that focuses on real outcomes for individuals.

Collateral materials are available that support this description on best practice. Implementation to assure that each consumer who receives supports and services experiences the "best practice" that the system has to offer requires training that is tailored towards case managers and those charged with implementing best practices in the system. There are extensive resources that are specific to various programs and/or strategies that the system will endorse for consideration by consumers, families and those who support them.

Substance Abuse Resources

For specific resources related to injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs populations see the following SAMHSA/CSAT Treatment Improvement Protocols:

- Tip 6: Screening for Infectious Diseases among Substance Abusers
  http://ncadi.samhsa.gov/govpubs/bkd131/
- Tip 10: Assessment and Treatment of Cocaine-Abusing, Methadone-Maintained Patients
  http://www.health.org/govpubs/bkd157/default.aspx
- Tip 11: Simple Screening Instruments for Outreach for alcohol and Other Drug Abuse and Infectious Diseases

  http://ncadi.samhsa.gov/govpubs/bkd143/
- Tip 13: The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Abuse

  http://www.treatment.org/Externals/Tip-13/TIP-13toc.html
- Tip 15: Treatment for HIV-Infected Alcohol and Other Drugs Abusers

  http://www.health.org/govpubs/bkd163/
- Tip 18: The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers

  http://ncadi.samhsa.gov/govpubs/bkd173/
- Tip 20: Matching Treatment to Patient Needs in Opioid Substitution Therapy

  http://www.health.org/govpubs/bkd168/
- Tip 22: LAAM in the Treatment of Opiate Addiction

  http://www.health.org/govpubs/bkd170/
- Tip 37: Substance Abuse Treatment for Persons with HIV/AIDS

  http://hstat.nlm.nih.gov/hq/Hquest/fws/T/db/local.tip.tip37/

For specific resources related to substance abusing women with children and DSS-involved parents who are substance abusers this target populations see the following SAMHSA/CSAT Treatment Improvement Protocols:

- Tip 2: Pregnant, Substance–Using Women

  http://ncadi.samhsa.gov/govpubs/bkd107/
- Tip 5: Improving Treatment for Drug Exposed Infants

  http://ncadi.samhsa.gov/govpubs/bkd110/
- Tip 13: The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Abuse

  http://www.treatment.org/Externals/Tip-13/TIP-13toc.html
- Tip 25: Substance Abuse Treatment and Domestic Violence

  http://ncadi.samhsa.gov/govpubs/BKD239/
- Tip 27: Comprehensive Case Management for Substance Abuse Treatment

  http://store.health.org/catalog/productDetails.aspx?ProductID=15653
- Tip 35: Enhancing Motivation for change in Substance Abuse Treatment

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip35
- Tip 36: Substance Abuse Treatment Responding to Child Abuse and Neglect Issues

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip36

For specific resources related to children and Adolescents with primary substance-related disorders populations see the following SAMHSA/CSAT Treatment Improvement Protocols:

- Tip 3: Screening and Assessment of Alcohol and Other Drug-Abusing Adolescents

  http://ncadi.samhsa.gov/govpubs/BKD306/
- Tip 4: Guidelines for the Treatment of Alcohol and Other Drug Abusing Adolescents

  http://ncadi.samhsa.gov/govpubs/BKD307/
- Tip 21: Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System

  http://www.health.org/govpubs/bkd169/

For specific resources related to the substance abusing adults involved in the criminal justice system population see the following SAMHSA/CSAT Treatment Improvement Protocols (TIP):

- Tip 7: Screening and Assessment for Alcohol and Other Drug Abuser among Adults in the Criminal justice System

  http://ncadi.samhsa.gov/govpubs/bkd138/
- Tip 12: Combining Substance Abuse Treatment with Intermediate Sanctions for Adults in the Criminal Justice System

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip12

- Tip 17: Planning for Alcohol and other Drugs Abuse Treatment for Adults in the Criminal Justice System

  http://ncadi.samhsa.gov/govpubs/bkd165/

- Tip 13: The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Abuse

  http://www.treatment.org/Externals/Tip-13/TIP-13toc.html

- Tip 23: Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing

  http://ncadi.samhsa.gov/govpubs/BKD205/

- Tip 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community

  http://ncadi.samhsa.gov/govpubs/BKD308/

- Tip 35: Enhancing Motivation for Change in substance Abuse Treatment

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip35/

For specific resources related to the deaf and hard of hearing population see the following:

- Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing

  http://www.mncddeaf.org/

For specific resources related to the high management adult substance abusers (includes sub-populations of co-occurring and homeless individuals) population see the following SAMHSA/CSAT Treatment Improvement Protocols:

- Tip 9: Assessment and Treatment of Patients with Co-Existing Mental Illness and Alcohol and Drug Abuse

  http://ncadi.samhsa.gov/govpubs/bkd134

- Tip 19: Detoxification from Alcohol and Other Drugs

  http://www.health.org/govpubs/BKD172/

- Tip 27: Comprehensive Case Management for Substance Abuse Treatment

  http://ncadi.samhsa.gov/govpubs/BKD250/

- Tip 29: Substance Abuse disorder Treatment for People with Physical and Cognitive Disabilities

  http://ncadi.samhsa.gov/govpubs/BKD288/

- Tip 38: Integrating substance Abuse Treatment and Vocational Services

  http://ncadi.samhsa.gov/govpubs/bkd381/

For specific resources related to the DWI Offenders population see the following SAMHSA/CSAT Treatment Improvement Protocols:

- Tip 13: The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Abuse

  http://www.treatment.org/Externals/Tip-13/TIP-13toc.html
- Tip 35: Enhancing Motivation for Change in Substance Abuse Treatment

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip35

Appendix B: LME/ CFAC Relational Agreement

Governing Authority

And

The _____ Consumer and Family Member Advisory Committee

This agreement, entered into by and between the_____ Governing Authority, which is responsible for assuring the availability of local mental health, developmental disability, and substance abuse services, with central office located at _____ , _____, NC,_____ and the local _____ Consumer and Family Advisory Committee (CFAC), as established by the _____ Governing Authority shall be in effect for _____ from the date of the signatures of both parties.

PURPOSE: to establish the relationship, roles and responsibilities of the CFAC to the governing body.

DEFINITIONS;

The Authority - the most local level of governance, such as an Area Board or County Board;

Local Management Entity (LME) - management, specifically the Director of the entity;

Consumer and Family Advisory Committee (CFAC) - those consumers and family members who were appointed to the committee consistent with the State Plan.

Responsibilities of the Parties

CFAC:

- Advise and comment on all local business plans to the LME, stakeholders and the Division;
- Make recommendations on areas of service eligibility and service array, including identifying gaps in services to the management and the governing authority;
- Assist in the identification of under-served populations and inform the governing authority;
- Provide advice and consultation regarding development of additional services and new models of service to the LME;
- Assist in monitoring service development and delivery; and issue a report of its findings to stakeholders and the LME;
- Review and comment on the local service budgets to the governing authority;
- Observe and report on the implementation of local business plans to the Division and the governing authority and

- Participate in quality improvement activities, including tracking and reporting on outcome measures and performance indicators;
- Recommend appointments to the LME;
- Support and orient its members;
- Defer official LME statement positions to the Authority.

THE AUTHORITY

- Identify the appropriate channels of communication in policy;
- Reply to recommendations of the CFAC;
- Recognize the contribution of consumers through their unique perspective and abilities;
- Establish a non-judgmental environment;
- Ensure timely advance notification of actions proposed;
- Ensure the LME provides the CFCA with support in the form of;
- Information and education regarding the service system, including funding sources, the system for access and service availability and materials regarding system reform practice platforms and models of best practice;
- Assistance in the creation of by-laws/operational procedures to ensure consumer/family participation and self –directed committee;
- Financial assistance for one or more of the following:

  1. Identification of stipends as appropriate to ensure participation;
  2. Transportation or compensation for travel expenses;
  3. Childcare and eldercare, if needed;
  4. Training in conducting meetings, negotiation skills, etc.

JOINT RESPONSIBILITIES

- Work together to achieve the responsibilities outlined in the State Plan;
- Work together to discover and develop service resources that lead to a more comprehensive, friendly and equitable system of services and supports;
- Work jointly to develop action plans regarding any issues/concerns with the _____ LME's core functions;
- Delineate a process of dispute resolution;
- Determine the level of professional staff participation necessary to ensure support but not control of the emerging CFAC and
- Approve by-laws and operational procedures that will support the self-directed functioning of the CFAC.

The _____ CFAC agrees to submit to the Division and the Governing Authority and County the following items:

1. Confirmation of consumer/stakeholder involvement consistent with the Blue Print for Change - State Plan 2002, July 1, 2002, submitted along with _____ LME's local business plan;

2. An annual report on the _____ LME's performance regarding local business plan development and implementation;

3. An indication that the core functions management plan is supported by the CFAC, or a report of issues/concerns along with an action plan jointly agreed upon by the LME and CFAC;

4. Documentation of all exceptions to the 30-mile/minute rule provisions;

5. A letter of endorsement of the community collaboration process and/or a report of issues and concerns; and

6. Documentation regarding the necessity for service provisions by the LME, if applicable.

DMH/DD/SAS agrees to:

- Maintain a relationship with all (CFAC, LME and Governing Board) parties to ensure that there are open lines of communication and act as a resource regarding the implementation of the reform effort;
- Assign the Chief of the Advocacy and Customer Services Section to act as the Division contact for the CFAC who will provide or ensure the availability of technical assistance to both parties;
- Assign the Chief of Advocacy and Customer Services Section to facilitate the resolution of issues involving the board and the CFAC when other avenues of resolution have not been successful.

TERMINATION

This Agreement may be terminated, in whole or in part, by mutual written consent of all parties or by any signing party, for cause upon 90 days written notice to the other parties and the Division of DMH/DD/SAS.

Signatures

Governing Authority Consumer and Family Member Advisory Committee

_____

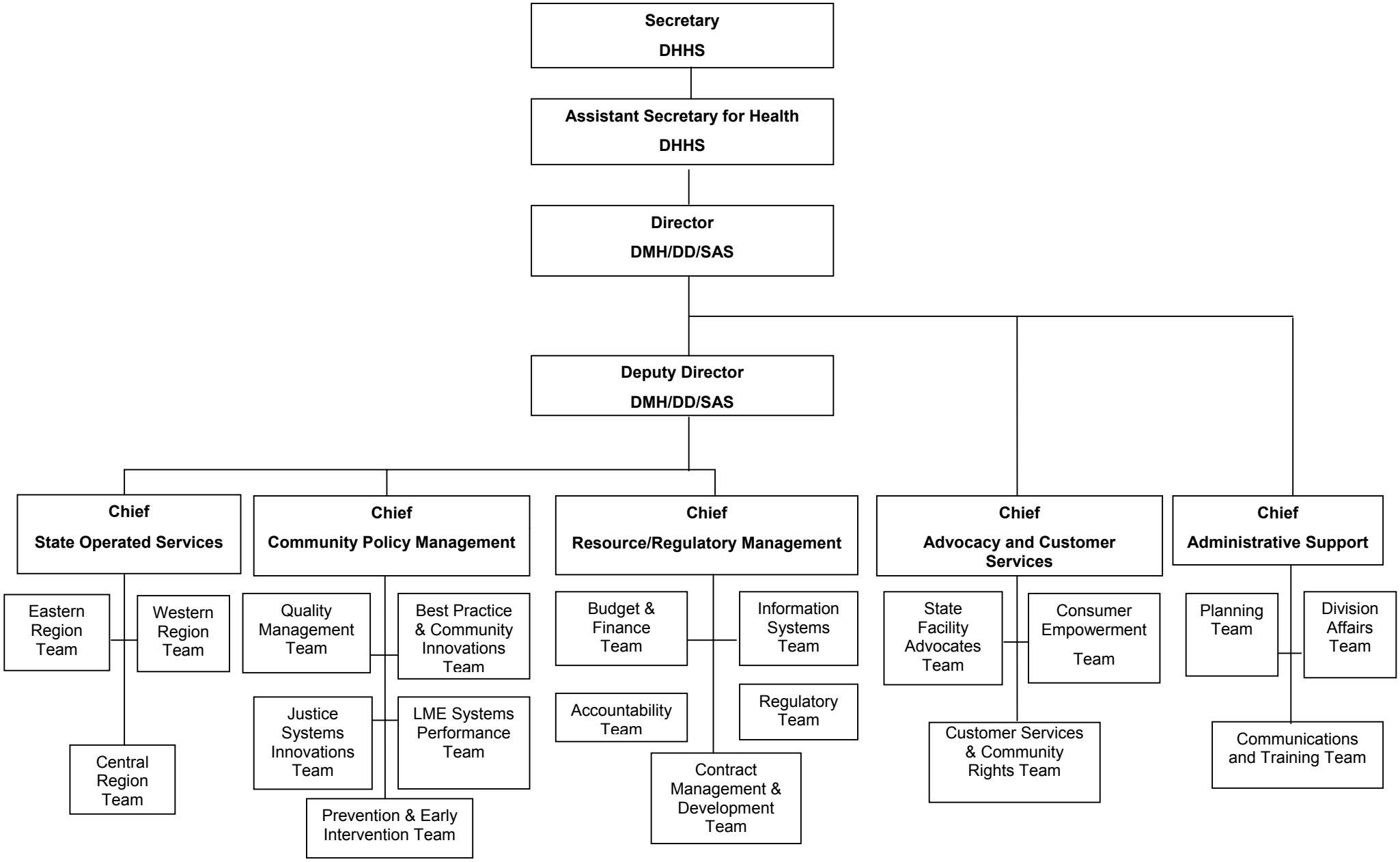
Chairperson Date

_____

Division of MH/DD/SAS Date

Chief of Advocacy and Customer Services

Appendix C: NCDHHS-DMHDDSAS ORGANIZATIONAL STRUCTURE



Appendix D: DIVISION OF MH/DD/SAS
COMMUNITY-BASED SUBSTANCE ABUSE SERVICES DEVELOPMENT (Revised 10-29-02)

Level of Care		Type of Program	Description	Licensure Designation	Whom Served *
Level 0.5-S (NC) Early Intervention	**N/A**	Selective Prevention	These services are designed to explore and address risk factors related to substance abuse through the implementation of an approved evidence-based selective prevention program in a wide variety of settings.	To Be Developed	Children/ Adolescents
Level 0.5-I (NC) Early Intervention	**N/A**	Indicated Prevention	These services are designed to explore and address problems and risk factors that appear to be related to pre-clinical substance use and to help the individual recognize the harmful consequences of inappropriate substance use.	To Be Developed	Children/ Adolescents
Level I Outpatient Treatment	**N/A**	**Outpatient** Counseling	This is a periodic service for individuals with substance abuse disorders. This service is designed to meet the clinically significant behavioral or psychological symptoms or patterns that have been identified as treatment needs of the recipient. This service is provided through scheduled therapeutic treatment sessions. This service includes: individual, group, family, and educational counseling.	Outpatient Facilities for Individuals with Substance Abuse Disorders (10 NCAC 14V Section .3500)	Adolescents Women Men
Level I (NC) Day Treatment	I.5	Day Treatment	Day Treatment is a service for adults and children that include a variety of services designed to meet the treatment needs of the individual consumer in a structured setting. This service must operate at least 3 days per week, but no fewer than 12 hours per week. A consumer shall be provided a structured program of treatment for a minimum of 5 hours per week. These services include individual, group, & family counseling, recreational therapy, peer groups, SA education, life skills education, & continuing care planning. Consumers may be residents of their own home, a substitute home, or a group care setting, however, the day treatment must be provided in a setting separate from the consumer's residence.	Day Treatment Facilities for Individuals with Substance Abuse Disorders (10 NCAC 14V Section .3700)	Adolescents Women Men

* Separation of adolescents, women and men in this column indicates the need for services that reflect the best practice for the population served.

** "Local" is within the LME/area program catchment area. "Multi" is provided across more than one LME/area program catchment area. "Regional" is one of three state designated regions.

Level of Care		Type of Program	Description	Licensure Designation	Whom Served *
Level II Intensive Outpatient	**II.1**	Day /Evening Treatment	Structured day & evening programs for adults and adolescents at least 9 hours of structured programming per week (in a min. of 3 days). These services include therapeutic or rehabilitation goals & individually specific treatment objectives designed to provide intensive substance abuse services that enable the consumer to maintain his residence in a non-institutional setting or to function successfully in a mainstream educational setting. Consumers may be residents of their own home, a substitute home, or a group care setting, however, the treatment must be provided in a setting separate from the consumer's residence.	Day Treatment Facilities for Individuals with Substance Abuse Disorders (10 NCAC 14V Section .3700)	Adolescents Women Men
Level OMT Opioid Maintenance Therapy	N/A	Opioid Addiction Treatment	Opioid addiction treatment is a service designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services. It is a tool in the detoxification and rehabilitation process of a narcotic dependent individual.	Outpatient Opioid Treatment (10 NCAC Section .3600)	Women Men
	III.05 (NC)	Transitional Independent Housing	Apartments or host homes supported with case management; or staffed apts.	To Be Developed	Women Men
		Transitional Congregate Housing	Low clinical intensity treatment & housing (e.g., Healing Place).	Exempt From Licensure	Adults
	III.1	Clinically Managed Low-Intensity Residential Treatment	Clinically managed low-intensity residential services are provided in a 24-hour facility were the primary purposes of these services is the care, habilitation or rehabilitation of individuals who have a substance abuse disorder, and who require supervision when in the residence. The consumers attend work, school or day treatment; and/or groups at night.	Supervised Living for Individuals of all Disability Groups (10 NCAC 14V Section .5600)	Adolescents Women Men

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Level of Care		Type of Program	Description	Licensure Designation	Whom Served *
	III.3	Clinically Managed Medium-Intensity Residential Treatment (Long term Supported Housing)	Clinically managed medium-intensity residential services include long term supported housing (12-18 months). The effects of addiction on the individual's life are so significant & the level of addiction-related impairment is so great that outpatient motivational strategies are not feasible or effective. Programming and staffing in this level of care is capable of addressing slightly more severe medical or emotional/behavioral problems. A structured recovery environment is combined with medium-intensity professional clinical services to support and promote recovery. Case management activity is directed towards networking residents into community-based ancillary or "wrap-around" services.	To Be Developed	Women Men
	III.5	Clinically Managed High-Intensity Residential Treatment (Therapeutic Communities)	Clinically managed high-intensity, highly structured, long-term residential treatment designed to treat the behavioral & emotional issues of individuals to promote self-sufficiency & a crime and drug-free lifestyle. Group Living is a 24-hour service that includes a greater degree of supervision and therapeutic intervention for the residents because of the degree of their dependence or the severity of their disability. The therapeutic community emphasizes self-help, abstinence from drugs and alcohol, personal growth, peer support & may serve as an alternative to incarceration. Services should be designed to create the environment of an extended family in which individuals develop self-esteem, construct a productive lifestyle through peer support and actual experience, leading to a successful re-entry into the larger community with approaches designed to confront & modify the consumer's antisocial and dysfunctional behavior.	**Therapeutic Communities (10 NCAC 14V Section .4300)**	**Adults**
		Clinically Managed High-Intensity Residential Treatment (Residential Recovery Homes)	Clinically managed high intensity, highly structured, long term residential treatment that is professionally supervised and provides trained staff who work intensively with individuals with substance abuse disorders who provide or have the potential to provide primary care for their children. The programs shall include, for each parent in the program, assessment/referral, individual and group therapy, therapeutic parenting skills, basic independent living skills, educational groups, child supervision, aftercare, follow-up and access to preventive and primary healthcare.	Residential Recovery Programs for Individuals with SA Disorders and Their Children (10 NCAC 14V Section .4100)	Pregnant Women and Women and their Dependent Children

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Level of Care		Type of Program	Description	Licensure Designation	Whom Served *
	III.7	Medically Monitored Intensive Inpatient Treatment	A residential treatment or rehabilitation facility for alcohol or drug abuse disorders that provides active treatment in a structured living environment for individuals with substance abuse disorders in a structured setting. Each facility shall provide or access to the following services: individual, group or family therapy for each consumer, educational counseling, including schools for minors; vocational counseling; job development and placement; money management; nutrition education; and referrals to supportive services including AA, NA, legal counseling, vocational, training and placement.	Residential Treatment for Individuals with SA Disorders (10 NCAC 14V Section .3400)	Women Men
Level IV Medically Managed Intensive Inpatient Treatment	N/A	Inpatient Treatment	Inpatient Hospital treatment involves the provision of 24-hour treatment in an inpatient hospital setting. This facility is designed to provide treatment for individuals who have acute psychiatric problems or substance abuse disorders and is the most intensive and restrictive type of facility for individuals. Services may include: psychological and medical diagnostic procedures; observation; treatment modalities, including medication, psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation and recreation therapy and milieu treatment; medical care and treatment and needed; supportive services such as education; and room and board.	Inpatient Hospital Treatment for Individuals who have Mental Illness or SA Disorders (10 NCAC 14V Section .6000)	Adolescents Adults

* Separation of adolescents, women and men in this column indicates the need for services that reflect the best practice for the population served.

** “Local” is within the LME/area program catchment area. “Multi” is provided across more than one LME/area program catchment area. “Regional” is one of three state designated regions.

Appendix D. *continued* DIVISION OF MH/DD/SAS
COMMUNITY-BASED SUBSTANCE ABUSE DETOXIFICATION SERVICES DEVELOPMENT (Revised 10-31-02)

Level of Care		Type of Program	Description	Licensure Designation	Whom Served	Local or Multi
Level I-D Ambulatory Detoxification without Extended On-Site Monitoring or Level II-D with Extended On-Site Monitoring	N/A	Outpatient Detoxification	An outpatient detoxification facility is a periodic service which provides services involving the provision of supportive services, particularly active support systems under the supervision of a physician for consumers who are experiencing physical withdrawal from alcohol and other drugs, including but not limited to appropriate medical, nursing and specialized substance abuse services. Outpatient detoxification services are be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs and to effectively facilitate the consumer's transition into ongoing treatment and recovery.	Outpatient Detoxification for Substance Abuse (10 NCAC 14V Section .3300)	Women Men	Local Local
Level III.2-D Clinically Managed Residential Detoxification	N/A	Social Setting Detoxification	Detox-Social Setting services are 24-Hour services which provide social support and other non-medical services to individuals who are experiencing physical withdrawal from alcohol or other drugs. Individuals receiving this service need a structured residential setting but are not in need of physician services; however, back-up physician services are available, if indicated. The service is designed to withdraw an individual from alcohol or other drugs, and to prepare him to enter a more extensive treatment and rehabilitation program.	Social Setting Detoxification (10 NCAC 14V Section .3200)	Women Men	Each LME is required to contract for at least one of the following:
Level III.7-D Clinically Managed Residential Detoxification	N/A	Non-Hospital Medical Detoxification	A 24-hour non-hospital residential service that provides medical treatment and supportive services under the supervision of a physician to individuals withdrawing from alcohol or other drugs and to prepare him/her to enter a more extensive treatment rehabilitation program. This service includes facility-based crisis services.	Non-hospital Medical Detoxification for Individuals who are Substance Abusers (10 NCAC 14V Section .3100) & Facility Based Crisis Service for Individuals of all Disability Groups (10 NCAC 14V Section .5000)	Women Men	Level III.2-D, Level III.7-D OR Level III.9-D

* Separation of adolescents, women and men in this column indicates the need for services that reflect the best practice for the population served.

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Level of Care		Type of Program	Description	Licensure Designation	Whom Served	Local or Multi
Level III.9-D Medically-Managed Intensive Inpatient Detoxification	N/A	Secured Detoxification	An appropriately licensed acute care setting able to provide medically directed acute detoxification and related treatment aimed at alleviating acute emotional/behavioral and/or biomedical distress resulting from the patient's use of alcohol/other drugs. These facilities are capable of admitting difficult-to-manage and/or combative individuals. Services offered in special Crisis/detox Units in the Alcohol and Drug Treatment Centers and other specialty units across the state.	Non-hospital Medical Detoxification for Individuals who are Substance Abusers (10 NCAC 14V Section .3100) & Facility Based Crisis Service for Individuals of all Disability Groups (10 NCAC 14V Section .5000)	Women Men	
Level IV-D Medically-Managed Intensive Inpatient Detoxification	N/A	Inpatient Hospital Care	Inpatient Hospital is a 24-Hour service that provides intensive treatment in a hospital setting. Supportive nursing and medical care are provided under the supervision of a psychiatrist or physician. This service is designed to provide continuous treatment for individuals with acute psychiatric or substance abuse problems.	Inpatient Hospital Treatment for Individuals who have MI or SA Disorders (10 NCAC 14V Section .6000)	Women Men	Local Local

* Separation of adolescents, women and men in this column indicates the need for services that reflect the best practice for the population served.

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Appendix E: LME Providing Direct Services

A program manages publicly funded services within a specified geographic area. County/area programs may not be the qualified providers of direct services, unless permitted by the secretary of DHHS through the approval of the local business plan with submission of Appendix A as required in *State Plan 2002: Local Business Plan*. Approval may be granted based on one or more of the following conditions:

- Pre-existing obligations.
- Access.
- Lack of available qualified providers.
- Service necessity as a model of best practice.
- Consumer choice in accordance with criteria established by the Secretary.

Requests for permission to provide services shall be made in conjunction with submission of the local business plan. Approval may be granted for a period of up to three years.

Required elements if requesting approval to provide direct services:

- There is a narrative explaining the intentions of the LME regarding services provision during the next three years.
- A Divestiture of Services policy is evident.
- A plan for divestiture is included and contains the identification of all services and a schedule of annual publication of RFA/RFP documents for each service.
- The plan contains a description of and a certification that the agency has developed a firewall (barrier) between the LME and case management functions.
- The application contains an attachment from the local Consumer and Family Advocacy Council regarding the necessity for service provision by the LME.
- The plan includes a list of contractual obligations that inhibit divestiture and a timeframe for eliminating these obstacles.
- There is a plan to eliminate services that do not meet best practice standards.

Requirements if approved:

- The county/area program must submit for each area for which it plans to provide service a description and history of at least the last two years of public/private relationships and contracting. Supply supportive evidence including minutes of meetings and efforts at public/private partnerships.
- County/area programs applying for approval to provide direct services other than core functions will focus their efforts on serving consumers in the targeted populations who have multiple, complex needs not easily met by individual or small group qualified providers.

- If approved to provide services other than core functions the county/area program must adopt written policies to assure that consumers are informed about the full array of qualified provider choices and that they are not steered toward services that are county/area program owned, operated, managed or affiliated. The policies must demonstrate:
  - The consumer has been provided with complete and non-biased information regarding the policy for qualified provider choice.
  - The consumer has reviewed all qualified provider options available to the consumer within the area.
  - The consumer indicates that it is his/her desire to retain the county/area program as the direct service qualified provider.

Service Divestiture Options

As part of the divestiture process, some area programs (APs) have initiated efforts of spinning out (movement of AP direct service staff to existing provider organizations) and/or spinning off (movement of AP direct service staff to newly developed provider organizations) as part of an overall strategy of developing a sound and comprehensive competitive provider network. The rationale behind spin out and spin off is as follows:

- To ensure that transition efforts are not disruptive and/or create a break in services for people with disabilities who are currently being served. This includes preventing a full-scale comprehensive shift at a single point in time of staff delivering services.
- As a mechanism to provide opportunities for staff to remain employed in the field, including increasing their certainty of future employment. This is particularly intended to minimize an increase in staff turnover and the corresponding problems in service delivery during the state reform transition timeframe.

These practices are acceptable, however they must adhere to the following conditions:

- They shall neither inhibit nor relieve the AP (emerging LME) of its responsibility to aggressively and continuously recruit and retain a competitive and comprehensive provider network.
- This effort shall be only a part of the overall provider network development strategy.
- The AP (emerging LME) shall have no tie to these organizations that is unlike the ordinary relationship they would have with any other provider organization (for example, the AP [emerging LME] director may not be on the organization's board of directors).
- These organizations shall be legally freestanding organizations.
- The transfer process shall not place these organizations at an unfair advantage over any other provider organizations.
- Any and all components of the transfer and transition shall not create an immediate or future unfair advantage over other provider organizations.
- From the point of transfer and into the future, these organizations shall be expected to compete in an equal and fair manner with all other comparable (in terms of services provided) provider organizations that are in the network.

As shall be expected of all provider organizations, these organizations shall be required to shift practice expectations to comply with best practice consistent with the State Plan. If service practice expectations as well as quality, effectiveness and efficiency expectations are not met (outcomes, systems performance and regulatory compliance), these organizations shall be treated equally and suffer the same consequences as any other provider organization. Area programs (emerging LMEs) who divest any or all of the services they currently directly deliver through the recruitment of suitable provider organizations must develop transition plans for the orderly transfer of service components. These plans are to assure that there is no disruptive break in services and that the people being served are fully informed and supported in their transition to the new arrangement.

An important change from *State Plan 2002: Blueprint for Change* concerns the provider-delivered service function of case management and the administrative (LME) function of systems management. Systems management includes the components of utilization management/ authorization and service coordination, which includes care coordination at the micro, consumer level and community collaboration at the macro, systems level. The overall goal is to re-align roles, responsibilities, expectations and funding to produce a recovery and self-determination oriented system of care for North Carolinians.

The ideal LME provides no direct services. Rather, the LME devotes its attention to managing and coordinating the array of services and supports across the entire region. However, every region has unique characteristics - greater or lesser numbers of potential network members, the presence or absence of specialty service providers or any number of other factors that impact local transition to the reformed system. Therefore, decisions about the LME providing direct services have to be made on a case-by-case basis, considering the specific circumstances. Factors to be weighed include:

- Efforts expended by the LME to attract and retain an adequate private provider network.
- Possible divestiture of current area program clinicians to a private, non-profit arrangement.
- Level of community support for the LME to continue providing some services pending development of an adequate network.

It is critical to keep people with disabilities, their families and communities at the forefront of all divestiture efforts. LMEs will not be required to divest of needed supports and services when there are no qualified providers available. Divestiture activities, as well as any other LME and provider network developments, should not cause disruptions in the lives of people with disabilities, their families and communities.